13. Claims Inquiries and Adjustments

Providers are responsible for ensuring that their claims are properly paid by Medicaid. This includes submitting claims correctly, tracking claims payments and resolving payment errors. This section tells you how to identify the cause of claims processing problems and resolve them.

13.1 Time Limits

When a claim is denied or otherwise paid incorrectly, you have 18 months to get an adjustment to EDS. The time period begins with the date of the RA that contained the error. The adjustment request must be received by EDS no later than 18 months after that date.

NOTE: In many instances, you may resubmit a denied claim as a new claim instead of sending an adjustment (see Step 7 in Section 13.3).

13.2 Lost Claims

A paper claim should appear on the RA as paid, denied, returned or in process within 30 days after being sent to EDS. An electronic claim submitted by 5:00 p.m. on the "electronic cut-off" date in the Medicaid Bulletin should appear in the RA issued with the next checkwrite.

If a claim does not appear on the RA when expected, inquire about the status of the claim through Voice Inquiry. Instructions for using this service are in Appendix C.

If there is no record of the claim as processed or pending, resubmit the claim.

13.3 Reviewing Denials

Claims are denied because the information in the claims processing system tells it not to pay you. This information may be incorrect - EDS may have made a keying error, you may have prepared the claim incorrectly, or other sources may have provided the wrong information. Before taking action, determine whether the denial is a valid denial or the result of incorrect information.

The following steps will help you to identify and resolve the common causes for denial.

Step 1 Determine the Reason for the Denial

Look at the EOB code on the RA for the denied claim. The meaning of the code is explained in the last section of the report. If you do not understand the explanation, contact EDS' Provider Services Unit. You need to know the reason for the denial before you can correct the problem.

Step 2 Does the Reason Appear Valid

Review your records and the applicable policies in this manual to see if the reason for the denial appears valid. Be sure to check the criteria and limitations for the service you billed.

If it appears that you should not have submitted the claim - that is, the service is not covered - no further action is needed. STOP HERE.

If it appears that you should be paid for the service - that is, the claim was denied due to incorrect information - go to the next step.

Step 3 Look for Errors on Your Claim

See if there are any errors on your claim. Be sure the facility's name and address on the claim match the name and mailing address you entered on your Medicaid Provider Agreement. Compare the name on the claim with the resident's name on the Medicaid card. Make sure the revenue and HCPCS codes were entered correctly on the claim. Compare the date(s) of service on the claim with your records (e.g., admission date, discharge dates, or previously paid claims). Check the other entries on the claim for accuracy.

- If you entered incorrect information on your claim, you must adjust the claim or submit another claim to be paid. Go to Step 7.

- If the information on the claim appears to be correct, go to the next step.

Step 4 Look for Data Entry Errors on the RA

Look for keying errors by comparing the information on the RA with the information on your claim. Compare the facility's name and address on the RA with the name and address on your claim. Compare the name on the RA with the resident's name on your claim. Compare the Medicaid ID number on the claim with the ID number on the RA. Make sure the revenue and HCPCS codes shown on the RA are the ones on your claim. Check the accuracy of the date(s) of service on the RA. Compare the other RA entries to those on your claim.

Step 5 Take Action Related to the Type of Denial

The source of most incorrect denials will be uncovered in the previous steps. If you have found the source of the error, go to Step 7.

If the previous steps do not reveal the error source, use the following guidance.

- **Medicaid Eligibility Denials**

  Eligibility denials are caused by information input for the claim not matching the resident's eligibility information in the State Eligibility Information System for the date of service (DOS). Erroneous denials are usually traced to errors on the claim or to keying errors; however, if following the previous steps did not reveal the source of the error, request assistance from DMA's Claims Analysis Unit. Send a copy of the claim, a copy of the RA, and a copy of the Medicaid ID card to the Claims Analysis Unit. If you used the Voice Inquiry System to verify the resident's Medicaid eligibility, attach a note stating the date that you verified eligibility through Voice Inquiry.

  If the resident is eligible, the Claims Analysis Unit will update the information on the State eligibility file and resubmit the claim to EDS for processing.

- **Disenfranchised Status Denials**

  If your claim for ACH/PC (Basic, Enhanced, or Therapeutic Leave) is denied because the resident is "disenfranchised" (EOB 9042), it means the resident is identified in the claims processing system as ineligible for the service on the DOS because of his Special Assistance (SA) eligibility status. Ask the SA Eligibility Specialist at the local department of social services to verify whether

the resident was disenfranchised on the billed DOS. If the resident was incorrectly identified as disenfranchised, the SA Eligibility Specialist must notify the Division of Social Services' Adult and Family Services Section, and you may resubmit the claim to EDS.

- **Enhanced ACH/PC Denials**

How you resolve denied Enhanced ACH/PC claims depends on the type of denial.

- **EOB 2235**

If your claim for Enhanced ACH/PC is denied with EOB 2235, it means that the Medicaid provider number authorized in the prior approval data base to receive Enhanced ACH/PC payments for the resident is not yours. Check with the ACH/CMS case manager to be sure the case manager has your correct Medicaid provider number. Ask the case manager to double-check the provider number entered in the prior approval data base. If your provider number was entered incorrectly into the data base, the case manager must correct the information in the data base before you resubmit your claim.

- **EOB 2236**

If your claim for Enhanced ACH/PC is denied with EOB 2236, it means the resident is not authorized in the prior approval data base to receive Enhanced ACH/PC payments on one or more of the DOS billed. Check with the ACH/CMS case manager to be sure of both the effective date and end date of the resident's Enhanced ACH/PC coverage. If the DOS billed is on or after the effective date and before the end date for coverage, ask the case manager to check the effective date and end date in the prior approval data base. If these dates were entered incorrectly into the data base, the case manager must correct them before you resubmit your claim.

- **EOB 2237**

If your claim for Enhanced ACH/PC is denied with EOB 2237, it means that the resident is not authorized in the prior approval data base on those DOS for the Enhanced ACH/PC payment rate (HCPCS code) billed. Check with the ACH/CMS case manager to be sure that the Enhanced ACH/PC payment rate (HCPCS code) you billed is the one authorized for this resident. If you billed correctly, ask the case manager to double-check the Enhanced ACH/PC payment rate (HCPCS code) entered in the prior approval data base. If the Enhanced ACH/PC payment rate (HCPCS code) was entered incorrectly into the data base, the case manager must correct it before you resubmit your claim.

- **EOB 2238**

If your claim for Enhanced ACH/PC is denied with EOB 2238, it means that there is no record of this resident having been authorized by an ACH/CMS case manager for Enhanced ACH/PC coverage in the prior approval data base. If you received an authorization to bill for Enhanced ACH/PC payments for this resident's care from an ACH/CMS case manager at the local department of social services or area mental health program, ask the case manager to help you resolve the problem. Make sure the case manager has the correct Medicaid ID number for the resident and your

correct provider number. Ask the case manager to be sure the correct Medicaid ID number and other authorization information was entered in the prior approval data base. If the resident's Medicaid ID or other authorization information was not entered into the data base or entered incorrectly, the case manager must correct it before you resubmit your claim.

- **Duplicate Service Denials**

  When the EOB states that your claim duplicates a previously paid claim, it usually means that EDS has paid a claim for the same service on the same DOS. Occasionally, it means that EDS has paid for a similar service on the same DOS or within the STATEMENT COVERS timeframe (item 6 of the UB-92).

  Check your records to see if you have already been paid for the service. Be alert to possible prior payments that may have had an incorrect DOS or incorrect number of units - due to your error or an EDS keying error. If you find such an error in a prior payment, adjust that payment. After the adjustment clears the system, resubmit the denied claim.

  Also, check to see if another Medicaid provider is providing services for the resident that might cause your claim to be considered a duplicate. For example, home health aide services billed by a home health agency are considered a duplicate service of ACH/PC. If you identify a duplicate service, it is your responsibility to resolve the problem with the other provider.

- **Excess Services Denials**

  When the EOB shows that the reason for denial is because your claim is for more services than is allowed for the resident, it usually means that EDS has paid a claim for the same service on the same DOS. Follow the same steps as for Duplicate Service Denials above.

If the reason for denial is not covered above and none of the suggestions above resolves the problem, go to the next step.

Step 6 Contact EDS for Guidance

If none of the previous steps resolves the problem, contact EDS Provider Services for help. Have your claim, the RA and related records in front of you when you call EDS.

Step 7 Resubmit the Claim

If you have found the source of the problem and you are within the time limit for submitting claims - that is, 365 days from the date of service - you can prepare and submit a new claim or resubmit the denied claim.

- **Prepare a New Claim**

  If the error was caused by an incorrect entry on the claim, prepare a new claim with the correct information and submit it to EDS.

- **Resubmit the Previous Claim**

  If the error was caused by a keying error, resubmit the previous claim to EDS. If the error was caused by incorrect information in the Medicaid claims processing system and/or the prior approval data base, resubmit the previous (original) claim to EDS after the information has been corrected.

REMEMBER: Before sending the claim to EDS, double-check all of the entries on the claim, not just those associated with the denial. This will help to prevent your getting a denial because another entry is incorrect.

If you are beyond the time limit for claims submission - that is, more than 365 days from the date of service - but within the 18 month limit for adjustments, you may still seek payment by the following two options:

- **Re-file the Claim**

  Re-file the claim if the entire claim was denied and the following information on the re-filed claim exactly matches the information on the RA for the denied claim:

  - The recipient's Medicaid ID number;
  - Your provider number;
  - The FROM date of service; and
  - The total units billed.

  You may re-file electronically or with a paper claim. Use this procedure to correct denials caused by minor errors such as leaving off the type of bill ("893") in item 4 of the UB-92, or having entered an invalid patient status code in item 22.

- **Request Time Limit Override**

  Request a "time limit override" according to the Medicaid Resolution Inquiry instructions in Section 13.6 in all other situations.

13.4 Incorrectly Paid Claims

Common types of incorrectly paid claims include those in which:

- You were paid for more units than you billed.
- You were paid for less units that you billed, and the number of units billed was within the limits for the service.
- You were paid for a different service than the one that you billed - the billing code (revenue or HCPCS) on the RA is not the one on the claim.
- You were paid for the wrong DOS - the DOS on the RA do not match those on the claim.

When a claim is paid incorrectly, send a completed Medicaid Adjustment form to EDS according to the procedures in 13.5

13.5 Using the Medicaid Adjustment Form

Use the Medicaid Adjustment form to adjust a previously paid claim or detail - that is, to correct an overpayment or underpayment.

You may copy the Medicaid Adjustment form in Appendix M for your use. Complete one Adjustment form for each claim being adjusted, using the following instructions:

Provider Number: Enter your provider number as it appears on the RA.

Provider Name & Address: Enter the name of the adult care home and address as they appear on the RA.

Recipient's Name: Enter the resident's name as it appears on the Medicaid card.

Recipient's ID: Enter the resident's Medicaid ID number as it appears on the Medicaid card.

DOS - FROM/TO: Enter the DOS for the entire claim to be adjusted or reviewed as entered in item 6 of the UB-92.

Claim Number: Enter the 13 digit internal claim number as shown on the RA. Reference only one ICN per Adjustment form. Refer to the original ICN, even if you have had a subsequent denial adjustment. For an adjustment that has a payment on a detail, reference the adjustment ICN as the claim number.

Please Check (type of adjustment): Check if this is an adjustment of an overpayment, underpayment, full recoupment, or any other reason. If you check "other," write in the reason for the adjustment in the blank to the right.

Under **Billed Amount**, leave blank.

Under **Paid Amount,** enter the total amount paid on the claim/detail.

Under **RA Date,** enter the date of the RA on which the paid claim appears.

Please Check Changes or Corrections: Check the appropriate item to indicate what is being corrected.

Please Specify Reason: Enter a clear, specific, and complete reason for the request. For example, if an underpayment was caused by an error in the number of units billed, indicate the correct service date and total number of units that should have appeared on the original claim.

Signature of Sender: Sign the form. If your signature is not easily legible, please print your name so that EDS knows who to contact if there are questions about the adjustment.

Date: Enter the date the Adjustment form is mailed to EDS.

Phone #: Enter your telephone number.

NOTE: Do not write in the space above the top line on the Adjustment form or in the area below your signature. Entries in either area will slow the processing of your adjustment.

Include the following with the Adjustment form when you send it to EDS:

- A copy of the RA referenced in the Adjustment form. If multiple RAs were involved in the claims payment, include a copy of each RA.
- If the referenced claim was a paper claim, send a copy of the claim. If the request involves a corrected or revised claim, send a copy of the original and revised claim. Do not obliterate previously paid details on the claim.
- Any additional pertinent information written on a separate sheet of paper. Do not write on the back of copies as the information is microfilmed on the front side only.
- Any medical records which pertain to the service rendered. If other information is attached, note its significance to the Adjustment request.

Send the Medicaid Adjustment form with the appropriate attachments to the address on the form. Within 30 days of receipt by EDS, the adjustment of the claim should appear on your RA as pending. If the adjustment does not appear on the RA as pending, make sure that the Medicaid ID number and ICN referenced on the Adjustment were complete and accurate. If they are not, correct the information and resubmit the Adjustment form.

13.6 Using the Medicaid Resolution Inquiry Form

Use the Medicaid Resolution Inquiry form to submit claims for time limit overrides and other claims requiring overrides prior to processing. You may also use this form to follow-up on a lost claim - one that did not appear on the RA when expected.

You may copy the Medicaid Resolution Inquiry form in Appendix N for your use. Complete the Resolution Inquiry form using the following instructions:

Please Check: Place a check mark in the appropriate box.

Provider Number: Enter your provider number as it appears on the RA.

Provider Name and Address: Enter the name of the adult care home and address as they appear on the RA.

Patient's Name: Enter the resident's name as it appears on the Medicaid card.

Recipient ID: Enter the resident's Medicaid ID number as it appears on the Medicaid card.

Date of Service - FROM/TO: Enter the Statement Covers Period DOS for the entire claim as entered in item 6 of the UB-92.

Claim Number: Enter the 13 digit internal claim number as shown on the RA if the claim was previously processed - otherwise, leave blank.

Billed Amount: Leave blank.

Paid Amount: Enter the total amount paid on the original claim.

RA Date: Enter the date of the RA showing the claim if the claim was previously processed - otherwise, leave blank.

Please Specify Reason for Inquiry Request: Enter a clear, specific, and complete reason for the request.

Signature of Sender: Sign the form. If your signature is not easily legible, please print your name so that EDS knows who to contact if there are questions about the request.

Date: Enter the date the Resolution Inquiry form is mailed to EDS.

Phone #: Enter your telephone number.

NOTE: *Do not write in the space above the top line on the Adjustment form or in the area below your signature. Entries in either area will slow the processing of your request.*

Include the following with the Resolution Inquiry form when you send it to EDS:

- A copy of the RA referenced in the Resolution Inquiry form. If multiple RAs were involved in the claims payment, include a copy of each RA.
- If the referenced claim was a paper claim, send a copy of the claim. If the request involves a corrected or revised claim, send a copy of the original and revised claim. Do not obliterate previously paid details on the claim.
- Any additional pertinent information written on a separate sheet of paper. Do not write on the back of copies as the information is microfilmed on the front side only.
- Any medical records which pertain to the service rendered. If other information is attached, note its significance to the Resolution Inquiry request.

Send the Medicaid Resolution Inquiry form with the appropriate attachments to the address on the form.